FALLON COMMUNITY HEALTH PLAN DIRECT CARE — MEMBERSHIP TRANSACTION FORM

GROUP INFORMATION

GROUP NUMBER	GROUP NAME
4450100	**Commonwealth of Massachusetts**
REQUESTED EFFECTIVE DATE	TYPE OF COVERAGE ❑ INDIVIDUAL ❑ FAMILY ❑ OTHER ____________________

REASON FOR TRANSACTION

ADDING COVERAGE
- ❑ New hire
- ❑ Annual open enrollment
- ❑ Other (explain in "Remarks" section below)

ENDING COVERAGE
- ❑ Termination of employment
- ❑ Change to other insurance (give name of other insurance in "Remarks" section below)
- ❑ Other (explain in "Remarks" section below)

CHANGES TO EXISTING COVERAGE

Change to:
- ❑ Individual ❑ Family ❑ Other
- ❑ Addition of a dependent (complete "Dependent" section below)
- ❑ Change in name, address, or other application information (give previous information in "Remarks" section below)
- ❑ Other (explain in "Remarks" section below)

EMPLOYEE INFORMATION

IF WE MAY CONTACT YOU BY E-MAIL, PLEASE SUPPLY ADDRESS WHERE INDICATED.*

NAME (LAST/FIRST/MI)	MAIDEN NAME (IF APPLICABLE)	PRIMARY LANGUAGE	BIRTH DATE	SEX ❑ M ❑ F	FCHP IDENTIFICATION NUMBER

STREET ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE ( )	SOCIAL SECURITY NUMBER

WORK PHONE ( )	DATE HIRED	AVERAGE NO. HOURS WORKED	DEPARTMENT #	EMPLOYEE #	IS YOUR SPOUSE EMPLOYED? ❑ YES ❑ NO	IF CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE TO ADD SPOUSE, GIVE DATE OF MARRIAGE: MO DAY YR

*E-MAIL	PLEASE WRITE IN YOUR PERSONAL PHYSICIAN SELECTION	EVER TREATED BY THIS PHYSICIAN? (IF YES, UNDER WHAT NAME?) ❑ YES ____________ ❑ NO	PHYSICIAN CODE	MEDICAL RECORD NUMBER

DEPENDENT INFORMATION

NAMES OF DEPENDENTS	BIRTH DATE	RELATION	SOCIAL SECURITY NUMBER	PRIMARY LANGUAGE	*E-MAIL	PERSONAL PHYSICIAN SELECTION (SEE PROVIDER LIST)	EVER TREATED BY THIS DOCTOR?	FOR FALLON USE ONLY – MEDICAL RECORD NUMBER / PHYSICIAN CODE
NAME (LAST/FIRST/MI—MAIDEN NAME IF APPLICABLE)	MO DAY YR	HUS ❑ WIFE ❑				PERSONAL PHYSICIAN SELECTION	❑ YES ❑ NO	M.R. P.C.
NAME (LAST/FIRST/MI)	MO DAY YR	SON ❑ DAU ❑				PERSONAL PHYSICIAN SELECTION	❑ YES ❑ NO	M.R. P.C.
NAME (LAST/FIRST/MI)	MO DAY YR	SON ❑ DAU ❑				PERSONAL PHYSICIAN SELECTION	❑ YES ❑ NO	M.R. P.C.
NAME (LAST/FIRST/MI)	MO DAY YR	SON ❑ DAU ❑				PERSONAL PHYSICIAN SELECTION	❑ YES ❑ NO	M.R. P.C.
NAME (LAST/FIRST/MI)	MO DAY YR	SON ❑ DAU ❑				PERSONAL PHYSICIAN SELECTION	❑ YES ❑ NO	M.R. P.C.
NAME (LAST/FIRST/MI)	MO DAY YR	SON ❑ DAU ❑				PERSONAL PHYSICIAN SELECTION	❑ YES ❑ NO	M.R. P.C.

REMARKS

AGREEMENT

I, the undersigned, am employed by the above named company working at least 30 hours per week, full time, or 20 hours part time, and I receive employer contribution to health insurance coverage. I hereby authorize my employer to deduct from my wages (if necessary) the amount I am responsible for contributing for the Fallon Community Health Plan coverage I have selected. I understand that FCHP is a health maintenance organization and that membership becomes effective in accordance with the FCHP Group Agreement and the FCHP *Evidence of Coverage*. I have read the back of this Membership Transaction Form and understand how to obtain and use services under my FCHP coverage. I certify that all information is correct to the best of my knowledge.

FOR FALLON USE ONLY	REASON CODE A T	TERRITORY	RECEIPT DATE	EMPLOYEE'S SIGNATURE	DATE	EMPLOYER'S SIGNATURE	DATE

 Agency payroll clerk: Mail white and yellow copies to FCHP Marketing Operations, 10 Chestnut St., Worcester, MA 01608. FCHP cannot process this form without authorized signature from employer.

TEMPORARY MEMBERSHIP CARD

WELCOME TO FALLON COMMUNITY HEALTH PLAN! Thank you for choosing Fallon Community Health Plan (FCHP) for your health coverage. In a short time you will receive a New Member Kit in the mail. This kit will include information on your membership in Fallon Community Health Plan and your membership card(s). In the meantime, this sheet is your **temporary membership card.** Also included in this kit will be an *Evidence of Coverage*, which defines your benefits and governs benefit decisions. NOTE: Requested effective date may not be actual effective date if it is not in accordance with the FCHP Group Agreement and the FCHP *Evidence of Coverage.*

DIRECT CARE: FCHP Direct Care offers you access to the nationally renowned Fallon Clinic as well as selected other providers throughout our service area. Fallon Clinic has more than 250 physicians practicing at 25+ convenient sites throughout central Massachusetts. Many Fallon Medical Centers are designed as full-service facilities for your convenience. **FCHP Direct Care lets you see any Fallon Clinic physician specialist*—without a referral.** When you have a Direct Care primary care physician, you may call any Fallon Clinic specialist directly for an appointment.

CHOOSING YOUR PHYSICIAN: You must also select a personal physician at the time of enrollment for every person covered under this contract: a doctor of internal medicine or family practice for adults and a pediatrician or family practice doctor for children. Please refer to your *Provider Directory* for a complete list of providers and their locations. You must make these selections now and list your choices on this Membership Transaction Form. If you wish to notify us of a physician change or if you need help choosing a physician, please call the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677).

MAKING APPOINTMENTS: Call your doctor's office or medical center directly to schedule appointments.

EMERGENCY CARE: *Emergency services do not require referral or authorization*. When you have an emergency medical condition you should go to the nearest emergency department or call your local emergency communications system (police, fire department or 911). If you receive care outside of the plan service area, Fallon Community Health Plan requires you to notify the plan within 48 hours or as soon as is medically possible. For more information on emergency benefits and plan procedures for emergency services, consult your *Member Handbook/Evidence of Coverage*.

OUT-OF-AREA CARE: When you are out of the service area you are covered for any unexpected illness or injury that needs prompt medical attention. Call FCHP Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) to report use of services, and call your doctor to arrange for follow-up care.

REMEMBER: FCHP will not pay for any services that are not provided or appropriately arranged by Fallon Community Health Plan, except in life-threatening emergencies in the area or any emergencies out of the service area.

CONSENT: Submission of this form indicates that you authorize anyone who provides medical services to you, your spouse or dependents to release to the plan any health information or medical records relating to those services for such routine needs as coordination of benefits, disease management programs, quality management, coordination of care, health services management, accreditation, and processing and payment of related claims.

QUESTIONS ABOUT COVERAGE? Call FCHP Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677), or visit our Web site at www.fchp.org.

* Specialty care providers include physicians, physician assistants, nurse practitioners and nurse midwives.